MoHealthNet

STATE OF MISSOURI

CHILDREN'S HEALTH INSURANCE PROGRAM AND SHOW ME HEALTHY BABIES

ANNUAL REPORT

DEPARTMENT OF SOCIAL SERVICES

DECEMBER 2022

EXECUTIVE SUMMARY

Established in 1998, the Missouri Children's Health Insurance Program (CHIP) provides essential health services to children in low-income families. As of December 2021, more than 119,000 children who would otherwise not have access to health coverage were enrolled in the program. Research has shown that access to healthcare helps improve both short-term and long-term outcomes for children. The investment in coverage for unborn children through the State of Missouri's (State's) Show Me Healthy Babies (SMHB) program helps improve birth outcomes for babies through the provision of prenatal care for pregnant mothers. For the State, it has been a winning investment. It has helped keep Missouri's children healthy at minimal costs to taxpayers.

This CHIP and SMHB annual report describes in further detail the history and current operations of the Missouri CHIP program, which include the SMHB program, as well as an evaluation of the program's goals. These quality goals, presented below, align with the State's overall quality strategy for MO HealthNet.

GOAL 1	GOAL 2	GOAL 3	GOAL 4	GOAL 5
				
Reduce the number of children and unborn children in Missouri without health insurance coverage.	Ensure appropriate access to care.	Promote wellness and prevention.	Ensure cost-effective utilization of services.	Promote member satisfaction with experience of care.

While there is positive information to report on each of these goals, Goal 4 in particular shows that CHIP has helped steer children to preventive care and better access to care in the community. This results in fewer unnecessary emergency room visits and hospital stays. Missouri's children are healthier as a result, and limited State resources spent on less costly care.

Since 2001, the rate of asthma-related hospital admissions and preventable emergency department visits among children enrolled in CHIP has declined. Pediatric asthma is a chronic, but treatable, condition and regular access to preventive care provided through CHIP has meant that families are able to better manage the condition and avoid traumatic and costly emergency visits. The rate of asthma-related emergency department visits among children enrolled in CHIP continues to be below the national benchmark and continues to be below the national average. Additionally, overall trends in preventable emergency department visits in the State are declining as a result of these interventions.

Between 2001 and 2020, the rate of preventable hospitalizations decreased by 44% for those enrolled in CHIP and by 60% for those enrolled in Missouri's non-CHIP Medicaid program. This is compared to a decline of 45% for those not on Medicaid or CHIP.

MO HealthNet for Kids – Medicaid/CHIP Program	
…helps improve outcomes for Missouri's children	…is helping to keep children healthier now and in the long term.
…makes good economic sense for Missouri	…means relative minimal costs to the State

CHIP is financed jointly by the state and federal governments.

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INTRODUCTION

The scope of this report is to address the statutory requirement to report on Missouri's Children's Health Insurance Program (CHIP) and Show Me Healthy Babies (SMHB) as required by State law (Sections 208.650 and 208.662.1 of the Revised Statutes of Missouri). Broadly, the report includes an evaluation of CHIP goal performance, including those outlined for the SMHB program.

THE HISTORY OF CHIP

When Congress enacted CHIP in 1997, there was growing concern about the rising uninsured rate among children in families with annual incomes just above the Medicaid income thresholds. Since its passage, the national rate of uninsured children has steadily declined; between 2020 and 2021, the child uninsured rate decreased 0.6 percentage points to 5%. Between 2020 and 2021, the number of children covered by Medicaid or CHIP increased by an estimated 752,000.[1] In 2020, Missouri's CHIP population started at 84,161 participants. By December 2021, CHIP coverage had reached 101,840 participants. CHIP health care coverage reached over 9 million children nationally in Fiscal Year (FY) 2020.[2]

While improved access to health care coverage is the overarching goal, several additional benefits are tied to expanded access to health care coverage. Notably, CHIP coverage is more affordable for families than either exchange or employer-sponsored coverage. Children with CHIP coverage are more likely to have a usual source of care, including dental care, and are more likely to have had a well-child visit in the past year compared to children without insurance.[3]

Research has shown access to Medicaid and CHIP has significant benefits to children and their families. With access to Medicaid, children in low-income families receive essential healthcare services and experience long-term benefits, including better health status, greater academic achievement, and increased future earnings. In addition, families with access to Medicaid and CHIP are less likely to experience financial insecurity and have medical debt.[4]

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1 https://www.census.gov/library/stories/2022/09/uninsured-rate-of-children-declines.html

2 https://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

3 https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf

4 https://www.americanprogress.org/issues/healthcare/reports/2019/06/12/470996/childrens-health-care-access-improve-universal-coverage-plans/

STATES AND THE CHIP PROGRAM

While CHIP has been successful in reducing the rate of uninsured children, it has also empowered states to design systems of coverage that meet state-specific needs. States can operate CHIP programs as a CHIP Medicaid expansion, a separate CHIP program or a combination of these two approaches. As of September 2007, the Missouri CHIP program has operated through a combination approach. Missouri receives a federal CHIP allotment based on its recent CHIP spending plus a growth factor.

Missouri has 2 years to spend each allotment and the federal government can redistribute any unspent funds to other states.[7]

The CHIP FMAP rate for Missouri is significantly higher than the FMAP rate, which is 64.96%. In State Fiscal Year (SFY) 2022, approximately $167 million was spent on services for CHIP populations, with $127 million financed by the federal government.

With such a large percentage of CHIP funding being financed by the federal government and dependent on both authorization and appropriations enacted by Congress, uncertainty about CHIP reauthorization and appropriations in recent years has created concerns among states about potential interruptions in CHIP services. In 2018, Congress passed legislation to provide CHIP funding through FY 2027, which provided longer-term clarity for CHIP operations at the state level.[8] The E-FMAP rate, which added 23% to the regular CHIP FMAP rate, was reduced in FY 2019. Through FY 2020, an additional Enhanced-Federal Match Percentage (E-FMAP) rate of 11%, rather than the previous 23%, was provided. As of FY 2021, the 11% E-FMAP was no longer provided after being phased out at the end of FY 2020.

State administrative rule (13 CSR 70-4.080) establishes the methodology used to determine CHIP enrollment eligibility.[9] Generally, in order for a child to be eligible for CHIP, a family must have an annual modified adjusted gross income (MAGI) of less than 300% of the federal poverty level (FPL). For children in families with MAGI between 150% and 300% of the FPL, there is an additional eligibility test of access to affordable coverage (affordability is defined on a scale from $86 to $216 per month based on family size and income).

[7] https://www.macpac.gov/subtopic/financing/

[8] A continuing resolution signed into law on January 22, 2018 (P.L. 115-120) and the Bipartisan Budget Act of 2018 signed into law on February 9, 2018 (P.L. 115-123) provided CHIP funding through FY 2027.

[9] https://s1.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c70-4.pdf

Comprehensive Eligibility Requirements for Families with Gross Income of More Than 150% of the FPL

Parents/guardians of uninsured children must certify the child does not have access to affordable employer-sponsored insurance (ESI) or other affordable, available health insurance coverage.

Infants under one-year-old in families with gross incomes of less than 196% of the FPL are exempt from premiums.

Children in families with gross incomes of more than 150% and up to 225% of the FPL are eligible for coverage once a premium payment is received.

Eligibility for the program may begin at the beginning of the month; however, coverage cannot begin until the premium payment is received.

Children in families with gross incomes of more than 226% and up to 300% of the FPL are eligible for coverage 30 calendar days after receipt of the application, or when the premium payment is received, whichever is later.

Any child identified as having special health care needs – defined as a condition that, left untreated, would result in the death or serious physical injury of a child – who does not have access to affordable ESI will be exempt from the 30-day waiting period in order to be eligible for services, as long as the child meets all other qualifications for eligibility.

The 30 calendar day delay is not applicable to children already participating in the program when a parent's income changes.

Pregnant women not otherwise eligible with gross incomes of less than 300% of the FPL are eligible for coverage under the SMHB program. SMHB participants can be determined presumptively eligible and have no cost-sharing requirements.

Premiums:

- Total aggregate premiums cannot exceed 5% of the family's gross income for a 12-month period.
- Premiums must be paid prior to delivery of service.

- Premiums will be updated annually and take effect on July 1 of each calendar year. A chart describing premiums effective July 1, 2022 is included as Appendix 1.

SMHB PROGRAM DETAILS

Missouri operates the SMHB program as a separate CHIP coverage option, which was created by State legislation enacted in 2014. SMHB was established to provide health coverage to unborn children by expanding coverage to mothers. The SMHB program enrollment began in 2016. The program was born from the recognition that children of women who have access to Medicaid during their pregnancy have better health outcomes that reach into adulthood, including reduced rates of obesity and hospitalizations, and improvements in oral health.[10] Without the SMHB program, the newborn would still be covered under Medicaid or CHIP, but associated healthcare costs would be greater due to the lack of prenatal care. With health coverage through SMHB, there is purposeful benefit of improving the health of the expectant mother, and in turn, the health of the child at birth.

SMHB

- Provides health coverage to unborn children by expanding coverage to mothers.
- Enrollment began in 2016.
- Covers pregnant women between 201% and 300% of FPL.
- Covers all prenatal care and pregnancy related services.

The SMHB program is separate from CHIP in that it covers pregnant women between 201% and 300% of the FPL. Covered services for an unborn child enrolled in the SMHB program include all prenatal care and pregnancy-related services for the mother that benefit the health of the unborn child, and promote healthy labor, delivery and birth. This also includes services such as care management, prenatal and postpartum home visits, breastfeeding education and electric breast pumps.

SMHB Eligibility Requirements

Pregnant

Household income up to 300% of the FPL

Uninsured

No access to ESI or affordable private insurance which includes maternity benefits (prenatal, labor and delivery, and post-partum coverage).

Is not eligible for any other MO HealthNet program, except Uninsured Women's Health Services, Extended Women's Health Services.

[10] https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf

SMHB has no waiting periods and is designed to provide medical assistance to the unborn child. The child will be covered from enrollment up to one year after birth (at that time the child may be eligible for Medicaid or CHIP). To help foster a child's healthy upbringing, certain eligible mothers may continue to receive pregnancy-related and postpartum care for up to 60 days after birth.

Table 1 illustrates income levels for Medicaid, CHIP and SMHB for children and pregnant women.

TABLE 1 – CHIP AND SMHB INCOME ELIGIBILITY

PROGRAM / AGE GROUP	0%-110% FPL	111%-148% FPL	149%-150% FPL	151%-196% FPL	197%-300% FPL
Children 0–1	Medicaid (Non-Premium)	Medicaid (Non-Premium)	Medicaid (Non-Premium)	Medicaid (Non-Premium)	CHIP (Premium)
Children 1–5	Medicaid (Non-Premium)	Medicaid (Non-Premium)	CHIP (Non-Premium)	CHIP (Premium)	CHIP (Premium)
Children 6–18	Medicaid (Non-Premium)	Medicaid/CHIP (Non-Premium)	CHIP (Non-Premium)	CHIP (Premium)	CHIP (Premium)
SMHB	SMHB (Non-Premium)	SMHB (Non-Premium)	SMHB (Non-Premium)	SMHB (Non-Premium)	SMHB (Non-Premium)

According to a study published in the American Journal of Obstetrics and Gynecology, prenatal care is associated with fewer preterm births[11], with far-reaching impacts on the overall health of the infant:

Medical Issues

Babies born prematurely suffer from a host of medical problems and are at considerable risk for long term impairment, including physical disability, cerebral palsy, mental retardation, and attention-deficit and hyperactivity disorder (ADHD).

NICU Infants

Medical experts estimate that a quarter of infants leaving neonatal intensive care units (NICUs) have chronic health problems. These chronic problems, including developmental delays and disabilities, put premature babies at risk for a variety of poor social outcomes as they age, including the inability to hold employment, extended residence in a parent's household, lowered socio-economic status, lower cognitive test scores, and behavioral challenges.

Infant Death Risk

In the presence of pregnancy complications, the lack of prenatal care was associated with increased preterm birth rates ranging from 1.6-fold to 5.5-fold for various antenatal high-risk conditions.[12]

[11] https://www.researchgate.net/publication/11355248_The_impact_of_prenatal_care_on_neonatal_deaths_in_the_presence_and_absence_of_antenatal_high-risk_conditions

[12] https://www.ajog.org/article/S0002-9378(02)00404-0/fulltext

Benefits of SMHB

The State's investment in prenatal care for low-income women through its SMHB program not only has the potential to improve health outcomes for newborns, but can also help conserve precious State resources.

Prenatal Care Generates Cost Savings (Particularly for Women with High-Risk Pregnancies)

Intensive prenatal care reduced hospital and NICU admissions		Cost Savings between $1,768 to $5,560 per birth, according to March of Dimes[13]
Average hospital charge for an infant of normal weight – $3,200		Average hospital charge for low birthweight babies[14] – $27,200

As discussed, there is growing evidence that connects the benefits of access to health coverage to better health outcomes and other social and economic benefits, which would be lost without CHIP and the SMHB program. Health care costs for families with low incomes would increase due to higher out-of-pocket expenses like deductibles. The burden would be particularly significant for children with special health care needs due the high cost of marketplace plans for that population. Some families might not be able to afford the increased costs, resulting in more uninsured children.[15] Without the SMHB program, healthier births would decline, but Missouri would remain obligated to cover these children after birth, likely at a greater cost due to their increased healthcare needs.

[13] https://www.healthaffairs.org/do/10.1377/hblog20160219.053241/full/
[14] https://www.americashealthrankings.org/explore/annual/measure/birthweight/state/ALL
[15] https://familiesusa.org/resources/the-childrens-health-insurance-program-chip/

EVALUATION OF CHIP GOALS

INTRODUCTION TO ANALYSIS

As previously noted, the Department of Social Services ("DSS" or the "Department") is required to submit an annual report on CHIP and SMHB that provides analysis on specific objectives/items identified by the Legislature. DSS is also required, by the Centers for Medicare & Medicaid Services (CMS), to develop a Quality Improvement Strategy (QIS). Missouri's QIS, which was updated in 2021, provides the framework to communicate the State's vision, goals, objectives and measures that address access to care, wellness and prevention, chronic disease care, cost-effective utilization of services and customer satisfaction. The QIS includes specific metrics that will be used to measure progress on a yearly and longer-term basis for each goal. While the QIS does not require measures to be broken out by CHIP or SMHB, it does include metrics that are specific to children as well as to pre- and post-natal care.[16] DSS is presenting its required analysis of the CHIP and SMHB programs in alignment with the framework outlined in the QIS quality goals. Specifically, this report is presented according to the four goals in the QIS, as well as one additional goal specifically related to reducing the number of children and unborn children in Missouri without health insurance. The report is structured according to the following goals, along with the relevant data and accompanying analysis that is required by statute:

GOAL 1	GOAL 2	GOAL 3	GOAL 4	GOAL 5
				
Reduce the number of children and unborn children in Missouri without health insurance coverage.	Ensure appropriate access to care.	Promote wellness and prevention.	Ensure cost-effective utilization of services.	Promote member satisfaction with experience of care.

[16] See Quality Improvement Strategy: 2021 Goals, Objectives and Measures; available at https://dss.mo.gov/mhd/mc/pages/quality-oversight.htm

Prior to 2018, the CHIP and SMHB report was focused on study questions rather than quality goals. DSS believes focusing the report on quality goals is helpful in providing consistent analysis and support for its mission.

EXPLANATION OF DATA SOURCES

This report uses previously aggregated, readily available data from the State of Missouri and the following sources:

- Health Status Indicator Rates – Department of Health and Senior Services (DHSS), Section for Epidemiology for Public Health Practice, CY 2019
- U.S. Census Data, 2000–2021
- Claims data from CY 2021
- Eligibility data from CY 2021
- Wraparound Service claims data – Department of Mental Health (DMH), CY 2021 DMH
- Health Effectiveness Data and Information Set (HEDIS) data from 2014–2021
- Consumer Assessments of Healthcare Providers and Systems (CAHPS) data from CY 2021
- Journal articles and health publications produced by the federal government and national health policy researchers (credited in the footnotes).

The most recent data available from these sources was used in compiling this report. To facilitate the comparison of longitudinal data across this year's report and previous years' reports, the same data sources have been used where possible and continue to be reported on a calendar year basis.

The COVID-19 public health emergency (PHE) provided continuous enrollment for members without annual redetermination assessments. This allowance affects the accuracy of data provided throughout the report, beginning with calendar year 2019. Data will level out following the PHE unwind anticipated in 2023.

CHIP/SMHB GOAL 1

GOAL 1

Reduce the number of children and unborn children in Missouri without health insurance coverage.

The mission of DSS is "to empower Missourians to live safe, healthy, and productive lives."[17]

Furthermore, the vision of the MO HealthNet Division is to build a best in class Medicaid program that addresses the needs of Missouri's most vulnerable in a way that is financially sustainable. Reducing the number of uninsured children and uninsured unborn children is fundamental to these goals and would not be possible without the CHIP and SMHB programs.

Below are details of enrollment information with separate discussions for the CHIP and SMHB programs. Because enrollment has been relatively stable over time, each participant had access to medically necessary services. As described above, the benefits of access to health coverage directly link to better health outcomes and other social and economic benefits, but those benefits can be difficult to measure.

CHIP Enrollment

Information provided on Tables 2, 3 and 4 below illustrates the number of CHIP participants by month, age, race and gender. Over the course of CY 2021, monthly CHIP enrollment ranged from 98,276 to 101,840 participants. Note these numbers do not include SMHB.

[17] See Quality Strategy: Mission (at pg. 7); available at https://dss.mo.gov/mhd/mc/pages/quality-oversight.htm

TABLE 2 – CY 2021 CHIP PARTICIPANTS BY ELIGIBILITY CATEGORY (EXCLUDING SMHB)

MONTH	MEDICAID/CHIP (NON-PREMIUM)[18]	CHIP (NON-PREMIUM)	CHIP (PREMIUM)	TOTAL
January	54,663	1,176	42,437	98,276
February	54,780	1,169	42,325	98,274
March	55,019	1,157	42,405	98,581
April	55,697	499	42,303	98,581
May	55,893	484	42,168	98,499
June	56,227	486	42,278	98,545
July	56,718	493	42,418	99,629
August	56,977	492	42,645	100,114
September	57,101	485	42,664	100,250
October	57,199	476	42,713	100,388
November	57,082	469	43,386	100,937
December	56,956	460	44,424	101,840

Data Source: CY 2021 eligibility data

[18] As a result of provisions contained in the Affordable Care Act children ages 6–18 in families with incomes between 100% of the FPL and the MAGI equivalent of 133% of the FPL are now a mandatory group under the Medicaid program. Before that requirement, Missouri covered these kids under CHIP. The Centers for Medicare & Medicaid Services (CMS) approved continuing to use CHIP funding to cover those kids who would have been CHIP under pre-MAGI eligibility determinations. Therefore, they are included in the report, although they are in a Medicaid eligibility category, and referred to as “Medicaid/CHIP non-premium”.

TABLE 3 – DECEMBER 2021 MEDICAID/CHIP (NON-PREMIUM)

GENDER	AGE	MEDICAID/CHIP (NON-PREMIUM)
	5 to 9	9,404
	10 to 14	11,364
	15 to 19	8,717
Male	**Total**	**29,485**
	5 to 9	8,771
	10 to 14	10,257
	15 to 19	8,443
Female	**Total**	**27,471**
Total		**56,956**

TABLE 4 – DECEMBER 2021 MEDICAID/CHIP (NON-PREMIUM)

RACE ETHNICITY	MEDICAID/CHIP (NON-PREMIUM)
White / Other	42,187
Asian	752
Black/African American	9,218
American Indian/Alaskan Native	182
Native Hawaiian/Pacific Islander	120
Multi-Racial	888
Unknown	3,609
Total	**56,956**

Medicaid and CHIP (excluding SMHB) Enrollment by county for December 2021 is provided in Appendix 2.

SMHB Enrollment

The information provided below illustrates the number of SMHB participants by month. This information was summarized based on eligibility data provided by DSS. Due to the nature of the program, enrollment in any given month may decrease as women will no longer be in the program when their eligibility ends.

TABLE 5 – CY 2021 SMHB PARTICIPANTS

Month	SMHB	Month	SMHB
January	2,692	July	3,243
February	2,778	August	3,375
March	2,878	September	3,466
April	2,986	October	3,425
May	3,063	November	3,169
June	3,166	December	2,923

Data Source: CY 2021 eligibility data

SMHB enrollment by county for December 2021 is provided in Appendix 3.

SMHB is instrumental in improving birth outcomes and providing coverage to unborn children who would otherwise not have access to health insurance. In the first year of SMHB (CY 2016), 1,069 babies were enrolled in SMHB. In CY 2021, 2,017 babies were enrolled. All of these children became eligible for regular CHIP/Medicaid upon birth.

TABLE 6 – CHILDREN BORN TO SMHB WOMEN BY MONTH

MONTH	YEAR	SMHB INFANTS
January	2021	173
February	2021	141
March	2021	187
April	2021	177
May	2021	189
June	2021	199
July	2021	194
August	2021	223
September	2021	199
October	2021	173
November	2021	146
December	2021	16
Total Current Enrollment Ending Dec 31, 2021		**2,017**

Data Source: CY 2021 eligibility data

Table 6 shows the number of children born to SMHB women in 2021. Table 7 compares newly enrolled pregnant women by month in the SMHB program and traditional Medicaid (MPW stands for MO HealthNet pregnant women). The MPW new enrollees were limited to the Pregnant Women Medicaid Eligibility (ME) codes (18, 45 and 61). Over the course of the year there were 2,277 unique pregnant women covered by the program. Due to the nature of the program, the enrollment in any given month may decrease as women will no longer be in the program when their eligibility ends. On December 31, 2021, there were 1,372 pregnant women enrolled in the SMHB program and 905 MPW.

TABLE 7 – NEWLY ENROLLED PREGNANT WOMEN BY MONTH			
Month	**Year**	**SMHB Women**	**MPW**
January	2021	56	55
February	2021	59	60
March	2021	89	101
April	2021	118	92
May	2021	81	70
June	2021	99	89
July	2021	101	89
August	2021	115	70
September	2021	125	50
October	2021	128	57
November	2021	201	105
December	2021	200	67

Data Source: CY 2021 eligibility data

SMHB Deliveries Compared to Other Programs

Tables 8 and 9 illustrate enrollment and deliveries across the SMHB, CHIP and non-CHIP (Medicaid) programs in Missouri. In comparing 2020 to 2021, the number of CHIP deliveries increased by approximately 71%, non-CHIP (Medicaid) deliveries decreased by approximately 5%, and SMHB deliveries decreased by approximately 2%. There was an increase in both CHIP and SMHB enrollment. Note: The large increase in CHIP deliveries is attributed to PHE data issues. This total will level out accurately upon successful unwind of the PHE.

TABLE 8 – TOTAL DELIVERIES IN 2021			
	SMHB	**CHIP**	**NON-CHIP (MEDICAID)**
Managed Care	2,116	6	25,330
Fee-for-Service (FFS)	6	1	492
Total	**2,122**	**7**	**25,822**

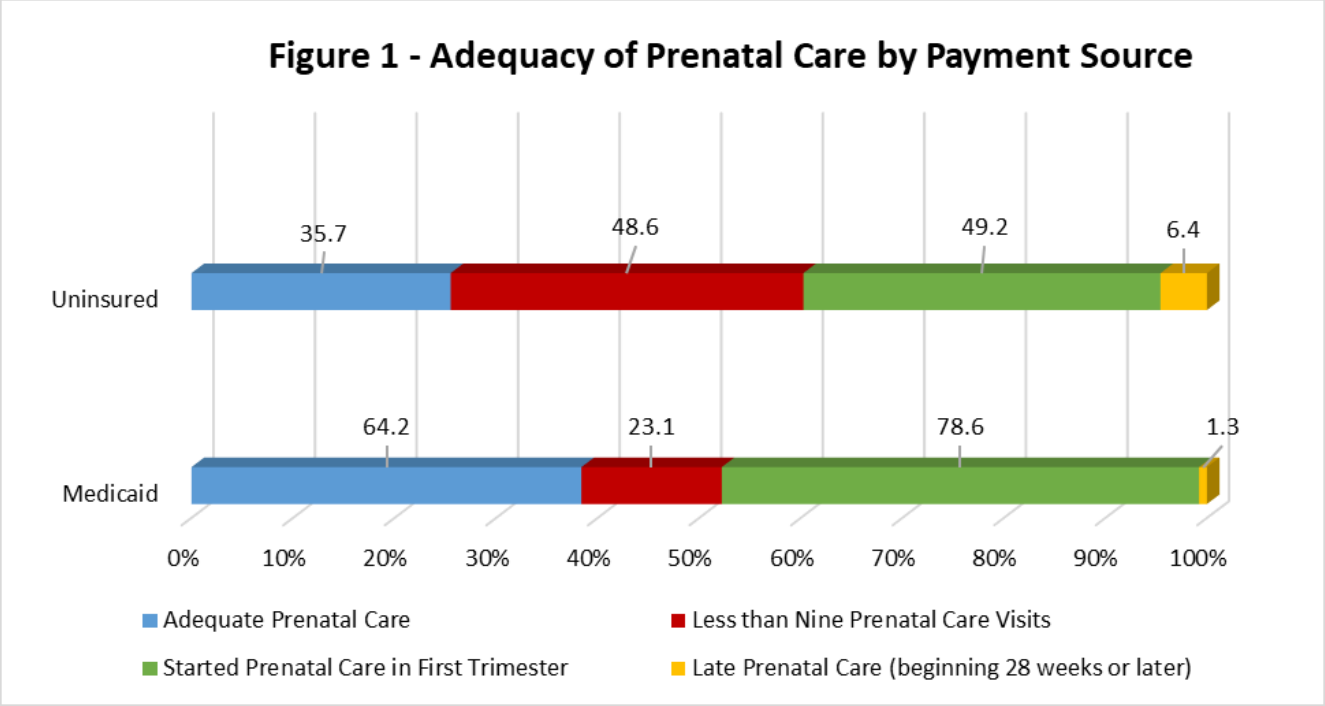
TABLE 9 – CHIP AND SMHB ENROLLMENT AND DELIVERY CHANGES CY 2020 AND CY 2021						
	DEC 2020 ENROLLMENT	DEC 2021 ENROLLMENT	CHANGE	2020 DELIVERIES	2021 DELIVERIES	CHANGE
CHIP	108,559	110,781	2.01%	2	7	71.4%
SMHB	3,209	2,923	-8.91%	2,171	2,122	-2.3%

Based on the eligibility criteria for the SMHB program, enrollees in general were previously uninsured. Comparison points to the SMHB program would be most relevant to pregnant women in the uninsured population; however, since the comparison population is uninsured, information is unavailable regarding their utilization of health care services. Therefore, this report focuses on different proxies or indicators that are likely related to the receipt of proper prenatal care.

Table 10 shows the number of births identified with very low birth weight (VLBW), which is defined by a birth weight under 1500 grams. Similar to the delivery counts shown in Table 10, these counts were determined by analyzing 2021 claims data. These metrics can serve as an indication of the prenatal services being received by pregnant mothers in each of the eligibility groups. It is expected that without adequate prenatal care, the prevalence of VLBW deliveries increases.

TABLE 10 – VLBW COUNT			
	SMHB	CHIP	NON-CHIP
Managed Care	14	0	455
FFS	4	1	138
Total	18	1	593

As discussed above, studies have shown that the earlier a pregnant woman has access to health coverage, the more likely she is to receive prenatal services. Figure 1 below contains results from a study by the Medicaid and CHIP Payment and Access Commission (MACPAC), indicating that only 35.7% of uninsured women receive adequate prenatal care compared to 64.2% for Medicaid. According to the study, women with Medicaid were more likely to experience timely and adequate prenatal care compared to women who were uninsured.[19]



Data Source: MACPAC analysis of the 2012-2014 Pregnancy Risk Assessment Monitoring System (PRAMS) data, 2017.

[19] https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf

Overall Impact of CHIP and SMHB on Health Care of Missouri Residents

The introduction to this report provides details on studies that have analyzed the impact of health insurance coverage on children's health. Studies clearly show that children with insurance have better health outcomes and higher academic success rates than uninsured children. Notably:

- Studies suggest there is a positive correlation between access to health insurance coverage and academic achievement.[20] Indeed, a 2016 report published by the Kaiser Family Foundation demonstrated the success of the CHIP program beyond improved health outcomes; research delineated a correlation between CHIP enrollment and improvement in school attendance, performance and motivation to pursue higher education.[21]
- Emerging evidence suggests that the health benefits continue through adulthood.[22]
- A 2016 report of compiled research published by the Kaiser Family Foundation found both Medicaid and CHIP provide broad benefits and cost-sharing protections for low-income children. Children enrolled in Medicaid received a comprehensive benefit package that includes the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, long-term care, many rehabilitative services, and service provided at Federally Qualified Health Centers (FQHCs). Under EPSDT, children are guaranteed comprehensive coverage including access to physical and mental health therapies, dental and vision care, personal care services and durable medical equipment.[23]
- In nine of ten studies cited in the Congressionally-mandated evaluation of CHIP, rates of unmet need were reduced by 50% or more as compared to pre-CHIP rates. Evidence further indicates that increased access is accompanied by reduced emergency department use.[24]

[20] http://jhr.uwpress.org/content/51/3/727.short

[21] Children's Health Coverage: The Role of Medicaid and CHIP and Issues for the Future. The Kaiser Family Foundation, March 2016.

[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4785872/#R49

[23] https://www.kff.org/report-section/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future-issue-brief/

[24] https://www.kff.org/report-section/the-impact-of-the-childrens-health-insurance-program-chip-issue-brief/

CHIP/SMHB GOAL 2

GOAL 2

Ensure appropriate access to care

After a child is enrolled in CHIP, it is imperative to ensure the child has access to care to take full advantage of the program. Access can be defined by, among other things, availability of providers accepting CHIP/SMHB participants who are located a reasonable distance from the participant's home. DSS measures access in managed care by reviewing provider directories and panels, maintaining appointment time and distance standards, and monitoring complaints.

The appointment time and distance standards are addressed in the QIS. In addition, DSS reviews CAHPS results to monitor participants' experiences with the Medicaid and CHIP programs. The CAHPS data is useful when considering whether members are receiving appropriate access to care.

In addition, the statute requires the Department to consider the effect of the CHIP program on the number of children covered by private insurance. Appropriate access to care also means ensuring that individuals who have access to private health insurance are utilizing that coverage.

Relevant CAHPS Information

CAHPS results for three important indicators related to children's access to both routine and specialty care are included in Table 11. Results for Missouri's CHIP program show that Missouri is above the national average for the specialty care access measure, and less than one percentage point from the national average for the preventive care access measure.

Table 11 - CAHPS INFORMATION ON ACCESS TO CARE FOR CHILDREN ENROLLED IN CHIP (2022)

CAHPS MEASURE	MISSOURI	NATIONAL HMO AVERAGE
In the last six months, when your child needed care right away, how often did your child get care as soon as he or she needed?	88.53%	92.84%
In the last six months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as he or she needed?	86.11%	86.87%
In the last six months, how often did you get an appointment for your child to see a specialist as soon as he or she needed?	91.55%	83.63%

Effect of CHIP on Number of Children Covered by Private Insurers

It is important to consider the effect of CHIP on the number of children covered by private insurance, and whether the expansion of health care coverage to children whose gross family income is above 185% FPL has any negative effect on these numbers.

"Crowd out" in the context of health insurance occurs when public coverage serves as a substitute for private insurance coverage. In such circumstances, individuals may choose to forgo coverage available from their employer or in the individual health insurance market because publicly funded coverage is more affordable or more comprehensive. Alternatively, employers may choose to drop coverage for their employees once public coverage becomes available for them.

When CHIP reauthorization legislation passed into law in 2008, Congress required states to develop procedures to prevent crowd out. Specifically, the law required states to adopt efforts to ensure that "the insurance provided under the State child health plan does not substitute for coverage under group health plans."[25] In Missouri's CHIP program, the State instills basic eligibility rules designed to prevent crowd out. A child must not currently have health insurance or access to affordable health insurance through a parent's employer. In addition, the State will utilize an affordability calculator to determine whether affordable insurance is available to a child in the private marketplace. Also, in order for the State to prevent crowd out, children within a CHIP eligible household with a Modified Adjusted Gross Income over 150%, up to but not including 300% of FPL, will be required to pay a premium in exchange for coverage.

In Missouri specifically, the State CHIP program has requirements to prevent crowd out, and evidence from 2013 to 2021, as shown below in Figure 3, demonstrates that the rate of both ESI and "direct purchase" insurance has increased slightly.[27] Both are indicators that CHIP has not been substituted for private insurance coverage. Missouri's rate of ESI and "direct purchase" insurance also stands above national trends (52.2% ESI nationally versus 57.00% in Missouri in 2021; 7.5% "direct purchase" insurance nationally versus 8.8% in Missouri in 2021). Beginning in 2016, the rate of uninsured children in Missouri also increased until 2019. Due to the impact the Covid-19 pandemic had on data collection, 2020 data for the Types of Insurance among Children in Missouri (Figure 2) was not released. Data collection resumed and was released in 2021 showing a decrease in the rate of uninsured children.

These data suggest that the expansion of the CHIP program has had little to no impact on the number of children covered by private insurance, and in fact, Missouri is outpacing the rest of the nation in maintaining private health insurance rates, both in overall percentage and over the last nine years. Figures 2-3 illustrate these nine-year trends.

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[25] 42 USC 1397bb(b)(3)(C)

[26] https://www.medicaid.gov/CHIP/Downloads/MO/MO-17-0002.pdf

[27] https://www.census.gov/library/publications/2022/demo/p60-278.html

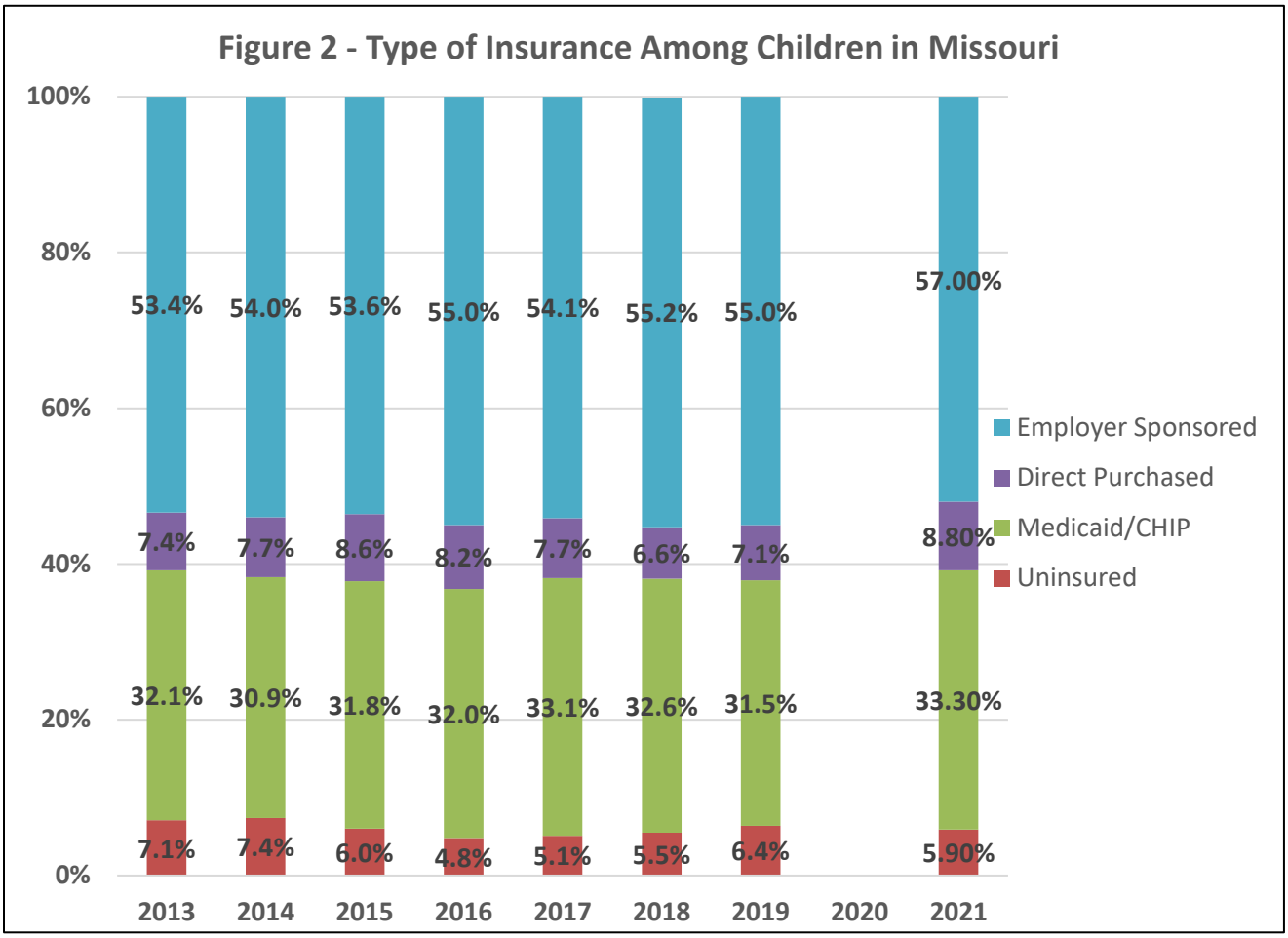
Figure 2 - Type of Insurance Among Children in Missouri
100%
80%
60%
40%
20%
0%
53.4%
54.0%
53.6%
55.0%
54.1%
55.2%
55.0%
57.00%
7.4%
7.7%
8.6%
8.2%
7.7%
6.6%
7.1%
8.80%
32.1%
30.9%
31.8%
32.0%
33.1%
32.6%
31.5%
33.30%
7.1%
7.4%
6.0%
4.8%
5.1%
5.5%
6.4%
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2013
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Employer Sponsored
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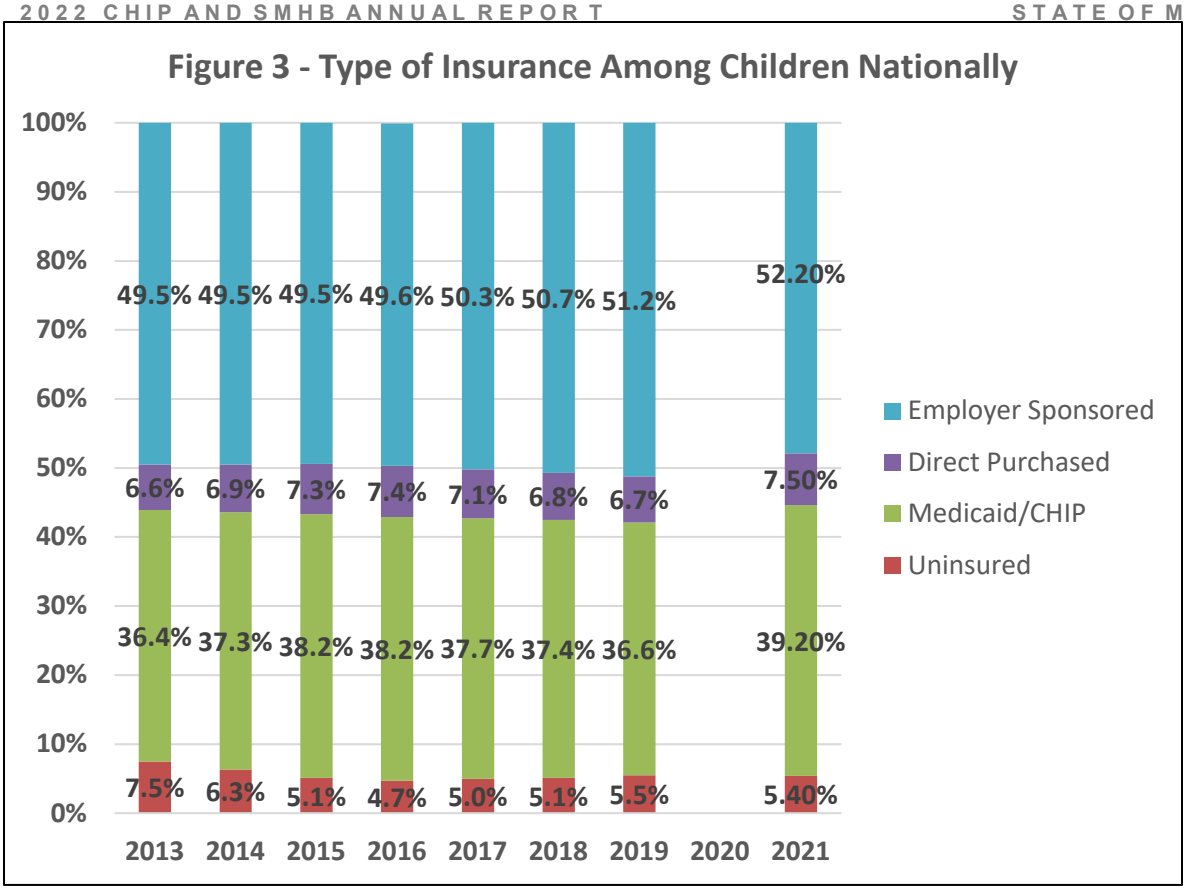
Medicaid/CHIP
Uninsured



Data Source: Health Insurance Coverage in the United States: 2021 Report
NOTE: Due to the impact of the COVID-19 pandemic, 2020 data is unavailable for Figures 2 and 3

CHIP/SMHB GOAL 3

GOAL 3

Promote wellness and prevention

Ultimately, providing health insurance to children and unborn children is expected to result in enhanced access to preventive care. This preventive care should, in turn, promote and impact wellness and overall health outcomes. In reviewing whether CHIP and SMHB coverage has furthered DSS' goal of promoting wellness and prevention activities, it is insightful to review the results of certain HEDIS measures. In addition, as required by statute, the discussion under Goal 3 also addresses the impact of CHIP on providing a comprehensive array of community-based wraparound services for seriously emotionally disturbed (SED) children and children affected by substance use.

HEDIS Measures

HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90% of US

health plans to measure performance on certain aspects of care and service.[28] DSS requires its managed care organizations (MCOs) to report on certain HEDIS measures, several of which are helpful to review when considering how DSS has made progress toward its goal of promoting wellness and prevention.

Missouri operates a Performance Withhold Program based on HEDIS measures.[29] The program withholds two-point-five percent (2.5%) of the per-member per-month payment (PMPM) to the contracted managed care organizations. Payment is then released on an annual basis based upon the health plan's improvement on the selected HEDIS measures.

DSS does not currently require HEDIS results to be stratified by Medicaid and CHIP; therefore, this report includes combined data for Medicaid and CHIP populations. While HEDIS includes a variety of measures, for purposes of this section of the report DSS is focusing on three specific measures: (i) Well-Child Visits in the First 15 Months of Life, (ii) Child & Adolescent Well-Care Visits (3-21 years), and (iii) members age 2–20 with dental benefits who had at least one dental visit during the measurement year.

TABLE 12 - HEDIS INFORMATION*

HEDIS MEASURE	HEDIS 2022	HEDIS 2021	HEDIS 2020	HEDIS 2019	HEDIS 2018	HEDIS 2017
Percent of members with six or more well-child visits in the first 15 months of life	50.10%	48.8%	61.3%	55.9%	61.8%	57.2%
Percent of members with well-care visits between ages 3–21**	42.60%	45.5%	58.1%	58.6%	65.7%	61.9%
Percent of members age 2–20 with dental benefits who had at least one dental visit during the measurement year	43.40%	42.3%	55.3%	49.5%	45.0%	46.9%

**The HEDIS Measure year includes data from the previous calendar year. For example, HEDIS 2022 reflects data from calendar year 2021.*

***HEDIS Measure* Percent of members with well-child visits between ages 3-6 *changed in HEDIS 2021 to* Percent of members with at least one comprehensive well-care visit between ages 3-21.

Community-Based Wraparound Services for Serious Emotional Disturbance (SED) Children and Children Affected by Substance Abuse

Wraparound services are a class of treatment and support services provided to a SED child and/or the child's family with the intent of facilitating the child's functioning and transition toward a better mental health state. Wraparound services include family support services, case management, respite care, targeted case management, community support services, transportation support, social and recreational support, basic needs support and clinical/medical support.

[28] https://www.ncqa.org/hedis/

[29] https://dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents/2022ManagedCarePerformanceWithholdTechnicalSpecifications.pdf

The Department of Mental Health (DMH) and the MO HealthNet Division (MHD) have developed joint protocols and guidelines for the provision of wraparound services. Funding is provided by a combination of state general revenue (DMH) and federal match dollars (MHD). DMH coordinates and oversees the delivery of these services.

DSS and DMH data on CHIP program eligibility, MCO enrollment and wraparound service utilization for CY 2021 were used for the purpose of this analysis. However, beginning in July 2017, DMH received a grant for a demonstration project that involved significant change to how services are reimbursed. As a result, payment for many services went from a FFS model to a bundled per diem payment. As the project is still relatively new, processes for the reporting of discreet service utilization within the bundled per diem are still under development.

While the MCOs are not required by contract to provide wraparound services, they often do so when it is cost effective as an alternative to more intensive levels of care. The average child receiving MC wraparound services received slightly more services than the average child receiving FFS wraparound services, as illustrated in Table 13 below. Figure 4 below shows how the mix of services differed for the time period of CY 2021 between the FFS and MC populations.

The statistics below, while informative, cannot be used on their own to determine the quality of wraparound services received by each population. There may be variances in each. Missouri continues to work with the Certified Community Behavioral Health Organizations (CCBHO) involved in the demonstration project to improve their claims data related to wraparound services and has made progress towards receiving daily claims data. The demonstration project has been extended through September 2023. The data reflected in the below charts do not include CCBHO data at this time.

Tables 13 and 14 show utilization rates of wraparound services by type for CY 2021.

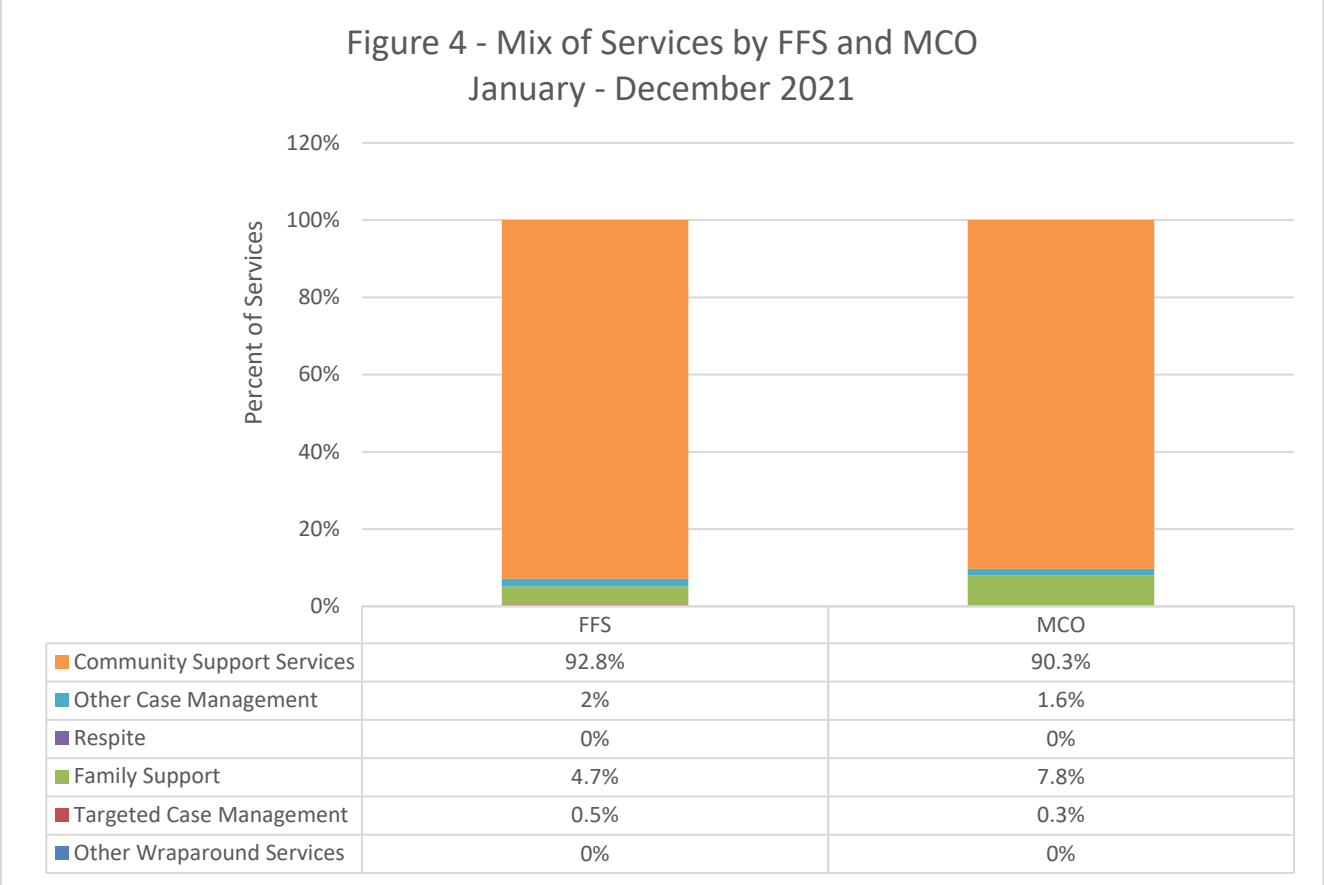
TABLE 13 – QUANTITY OF WRAPAROUND SERVICE UNITS

WRAPAROUND SERVICES	TIME PERIOD	FAMILY SUPPORT	OTHER CASE MANAGEMENT	RESPITE	TARGETED CASE MANAGEMENT	OTHER WRAPAROUND SERVICES	COMMUNITY SUPPORT SERVICES
FFS	1/2021 – 6/2021	378	52	0	22	0	4,117
	7/2021 – 12/2021	53	122	0	24	1	4,345
MCO	1/2021 - 6/2021	807	158	0	16	0	8,959
	7/2021- 12/2021	674	145	0	48	2	8,233

TABLE 14 – WRAPAROUND SERVICE UNITS PER CHILD

WRAPAROUND SERVICES	TIME PERIOD	FAMILY SUPPORT	OTHER CASE MANAGEMENT	RESPITE	TARGETED CASE MANAGEMENT	OTHER WRAPAROUND SERVICES	COMMUNITY SUPPORT SERVICES
FFS	1/2021 – 6/2021	8.3	1.1	0	0.5	0	90.1
	7/2021 – 12/2021	1.2	2.7	0	0.5	0	95.6
MCO	1/2021 – 6/2021	8.1	1.6	0	0.2	0	90.1
	7/2021 – 12/2021	7.4	1.6	0	0.5	0	90.5

Data Source: DMH wraparound claims data



Data Source: DMH wraparound claims data

CHIP/SMHB GOAL 4

GOAL 4

Ensure cost effective utilization of services

As stated in the QIS, cost-effective utilization of services is critical to the Department's ability to meet its mission of building a best in class Medicaid program that addresses the needs of Missouri's most vulnerable in a way that is financially sustainable. In evaluating cost-effective utilization of services, DSS reviewed data around preventable hospitalizations, emergency department utilization, SFY 2021 expenditures for CHIP and SMHB, and select HEDIS measures.

Preventable Hospitalization Summary

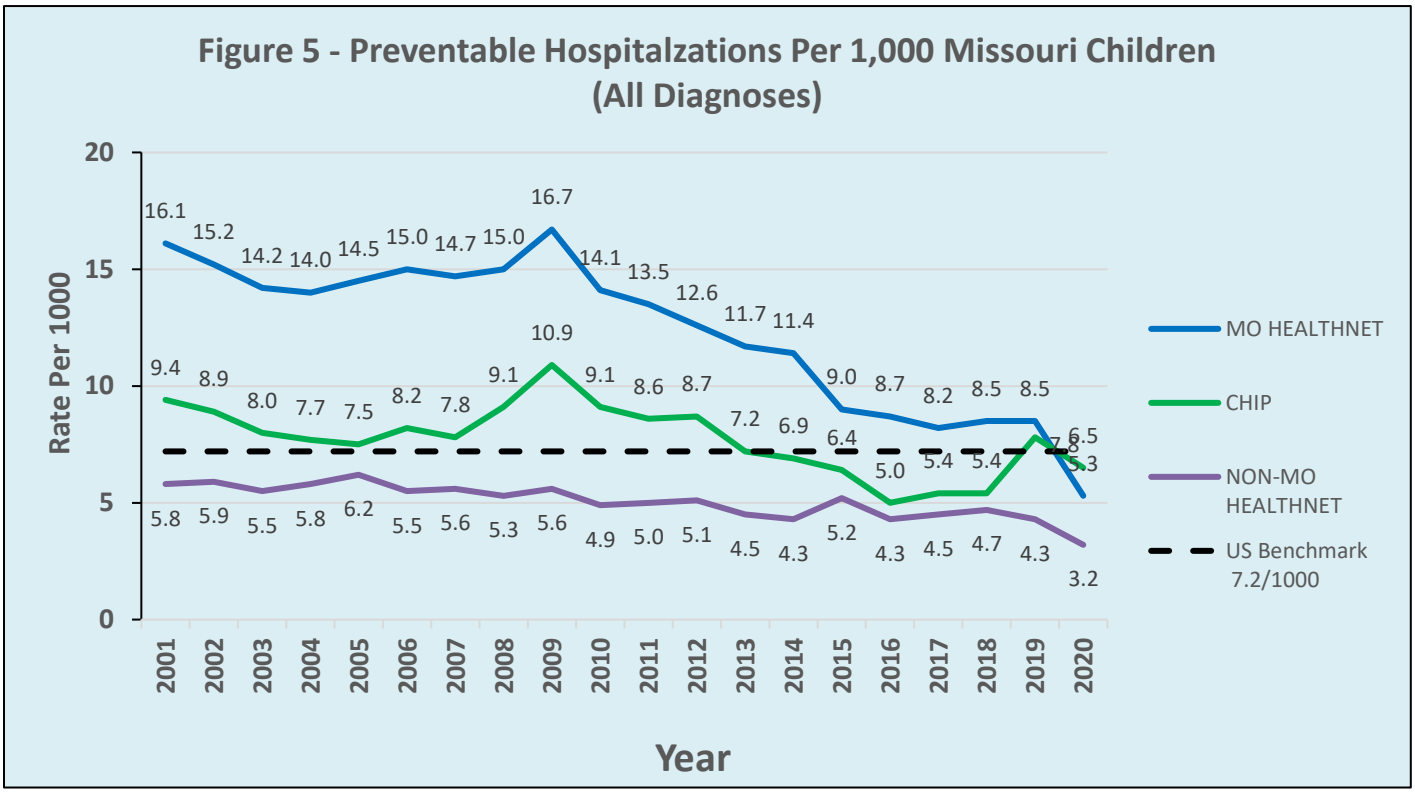
The data presented below look at four hospital indicators including emergency department use and hospitalizations. For CY 2020, three of the four indicators stayed relatively the same when comparing 2019 to 2020, however, all four indicators remain close to national benchmarks (lower scores are better).

Preventable Hospitalizations

From 2001 to 2020, preventable hospitalizations for the CHIP population decreased by 44%. During these time, preventable hospitalizations for the MO HealthNet (Medicaid children) population decreased by 60% while the preventable hospitalizations for the non-MO HealthNet group (children in Missouri who are not on Medicaid or CHIP) decreased by 45%.

In 2020, the CHIP population's preventable hospitalizations per 1,000 children was 5.3, which is approximately 36% below the national benchmark of 7.2 per 1,000.

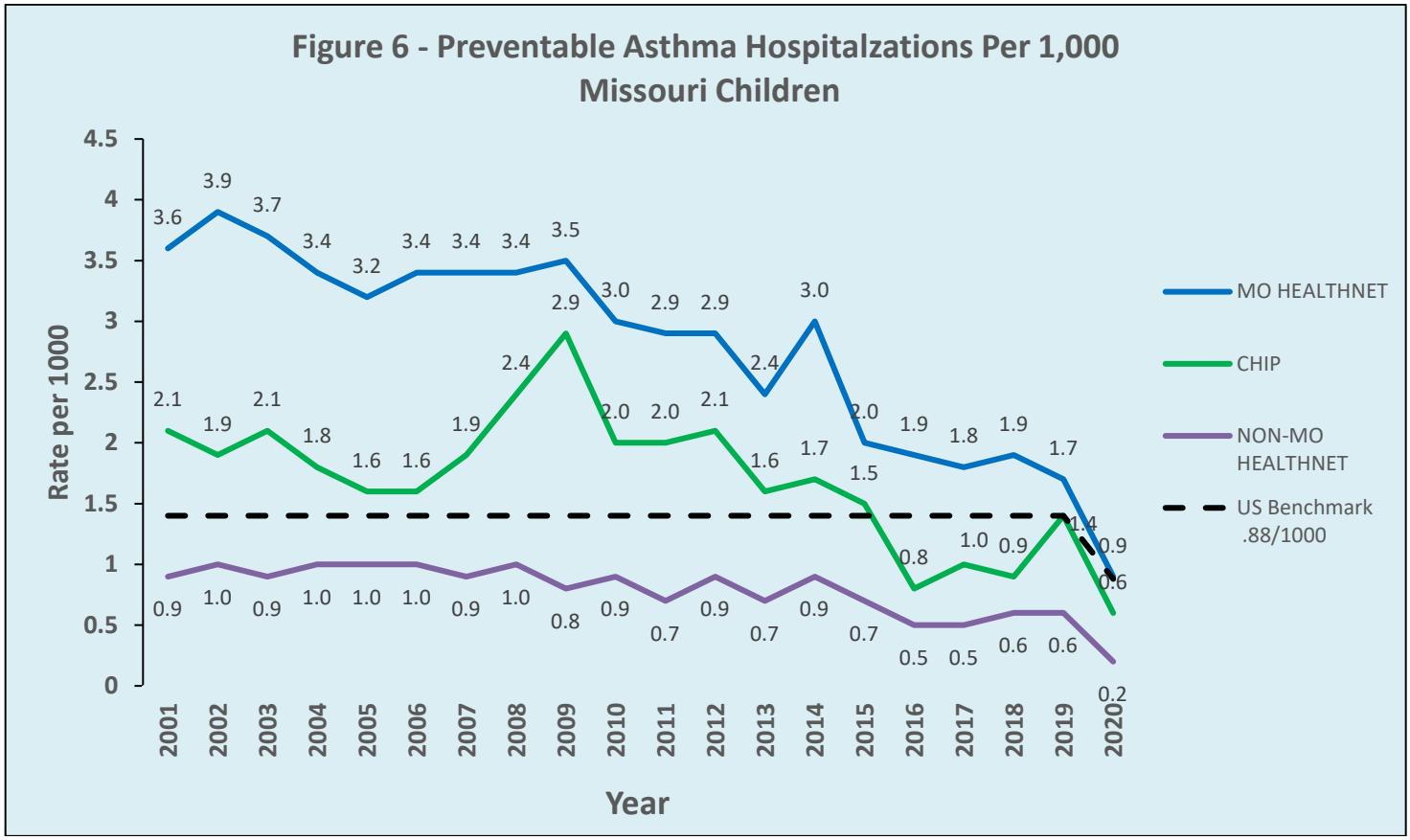
Notably, the MO HealthNet preventable hospitalizations rates continue to reduce since 2001 and move closer to the non-MO HealthNet population preventable hospitalization rates.



Data Source: DHSS Health Status Indicator Rates

Preventable Asthma Hospitalizations

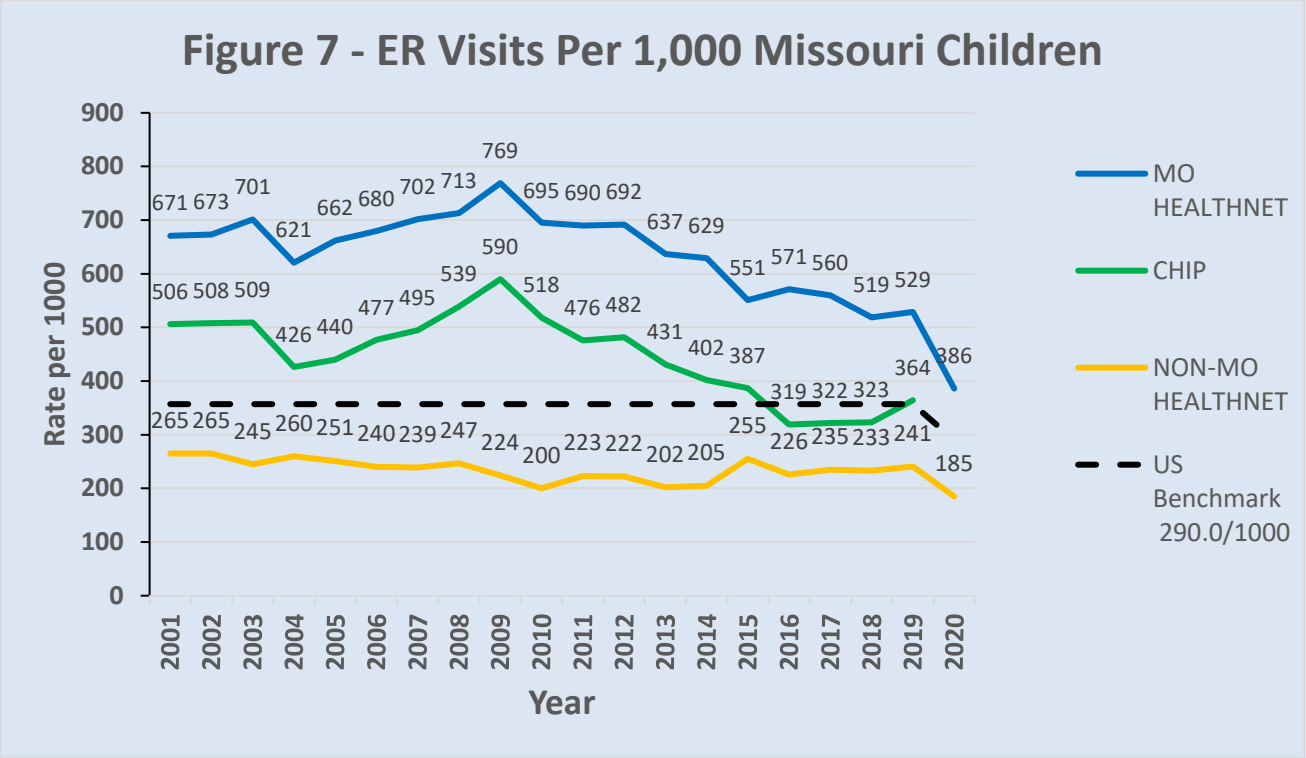
Since 2014, preventable hospitalizations due to asthma have historically decreased for the CHIP population and in 2020, the CHIP group's rate of 0.6 preventable asthma hospitalizations per 1,000 children was 32% below the national benchmark rate of .88 preventable asthma hospitalizations.



Data Source: DHSS Health Status Indicator Rates

Emergency Department Visits

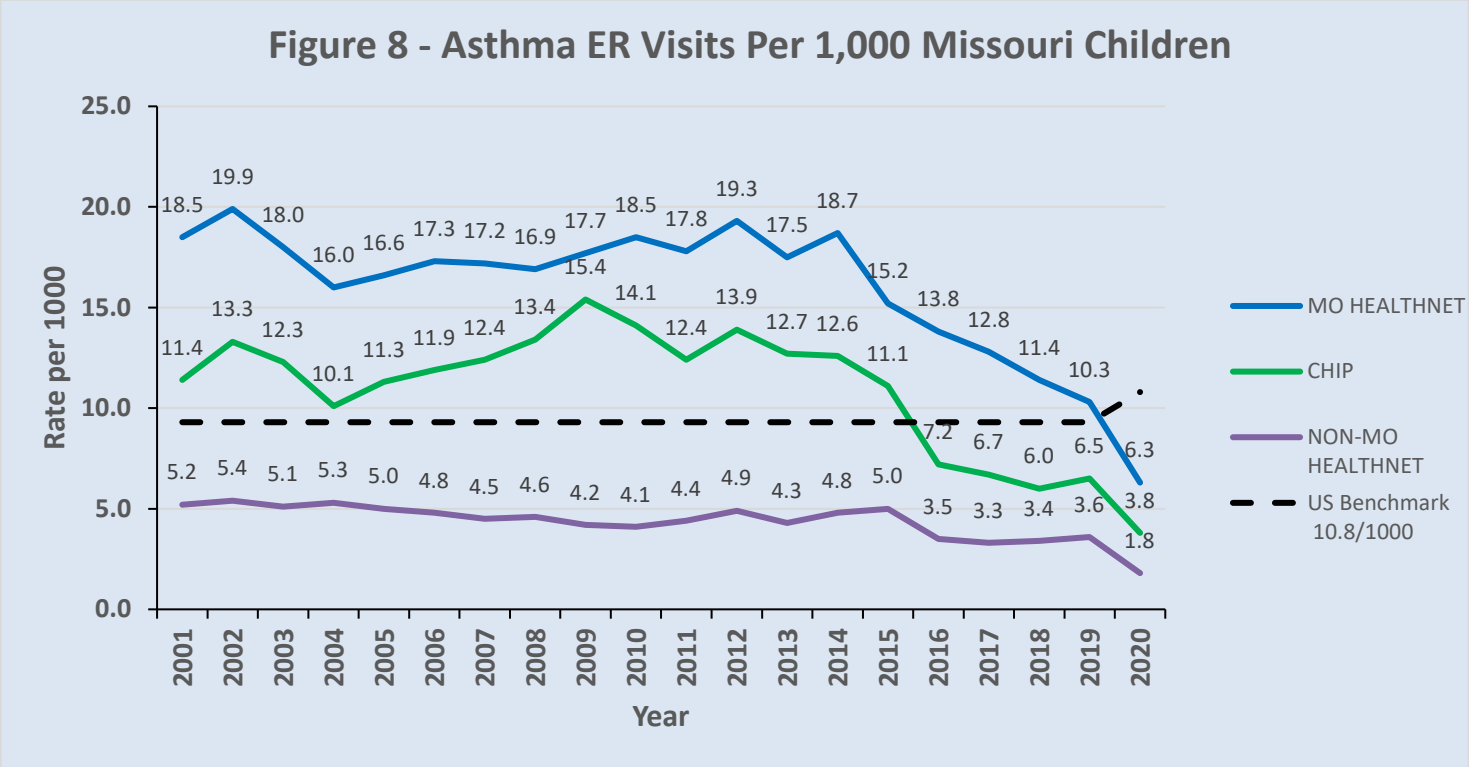
In 2020, the CHIP group's rate of 274 emergency department visits per 1,000 children was 5% lower than the national benchmark rate of 290 emergency department visits. Notably, the CHIP program has seen a decrease of 46% from 2001 to 2020 in emergency department visits. Over the same period, emergency department visits decreased by 42% for the MO HealthNet (Medicaid children) population and by 30% for the non-MO HealthNet group (children in Missouri who are not on Medicaid or CHIP).



Data Source: DHSS Health Status Indicator Rates

Asthma Emergency Department Visits

In 2020, the continuation of asthma emergency department visits for the CHIP population was lower than the national benchmark rate. Missouri continues to see a substantial decline in this area. The CHIP 2020 rate of 3.8 asthma emergency department visits per 1,000 children was 65% lower than the national benchmark rate of 10.8 visits per 1,000 children.



Data Source: DHSS Health Status Indicator Rates

A summary of the below indicators from 2020 is presented in Table 15. In 2018, MO HealthNet implemented an asthma education and in-home environmental assessment program for youth with uncontrolled asthma. This program helps further reduce ER utilization among the targeted population.

Detailed data by region and by year are included as Appendix 4 of this report. The COVID-19 PHE led to a significant decline in both hospitalizations and emergency department visits during 2020, thus leading to the dramatic percentage decreases shown in Appendix 4.

TABLE 15 – SUMMARY OF 2020 INDICATORS FOR MISSOURI CHILDREN UNDER AGE 19 PER 1,000 CHILDREN				
	CHIP	MO HEALTHNET (MEDICAID)	NON-MO HEALTHNET (NON-MEDICAID)	NATIONAL BENCHMARK
Preventable Hospitalizations	5.3	6.5	3.2	7.2
Preventable Asthma Hospitalizations	0.6	0.9	0.2	.88
Emergency Department Visits	274.1	385.9	185.1	290
Asthma Emergency Department Visits	3.8	6.3	1.8	10.8

Rates are per 1,000 population. For non-CHIP population, age is under 18.
Data Sources: DHSS

CHIP and SMHB Expenditures

CHIP and SMHB are funded through federal and State appropriations (both through general State revenue and other State agency dollars). The State share, however, is a small fraction of the total CHIP expenditures in Missouri.

TABLE 16 – CHIP SFY 2021 EXPENDITURES			
	CHIP	SMHB	GRAND TOTAL
State General Revenue	$31,990,275.41	$11,941,162.30	$43,931,437.71
Other Funds	$7,719,203.99	$0	$7,719,203.99
Federal Funds	$127,846,613.96	$37,201,293.11	$165,047,907.07
Total	**$167,556,093.36**	**$49,142,455.41**	**$216,698,548.77**

**Note: Other Funds include FRA, Pharmacy Rebate, Premium, PFRA and IGT.*

CHIP/SMHB GOAL 5

GOAL 5

Promote member satisfaction with experience of care

The last goal of the QIS is to promote member satisfaction with experience of care. While not required by statute, an important indicator of the success of the CHIP and SMHB programs is reviewing member satisfaction with experience of care. If members do not have positive interactions with the health care system, they may be less likely to participate in preventive care, which could result in later increased costs (e.g., through unnecessary hospital visits). To that end, the Department reviewed available CAHPS data and compared results with national standards.

CAHPS results for four indicators related to satisfaction with experience of care are included in Table 17. Results for Missouri's CHIP program show that Missouri is above the national averages with respect to satisfaction related to actual providers and satisfaction with the child's health plan.

TABLE 17 – CAHPS SATISFACTION WITH EXPERIENCE OF CARE RESULTS AMONG CHIP PARTICIPANTS

CAHPS MEASURE	MISSOURI CHIP	NATIONAL HMO AVERAGE
Proportion of respondents that would rate all their child's health care in the last six months an 8 or higher on a scale from 0-10 where 0 is the worst health care possible and 10 is the best health care possible.	90.40%	85.66%
Proportion of respondents that would rate their child's personal doctor an 8 or higher on a scale from 0-10 where 0 is the worst personal doctor possible and 10 is the best personal doctor possible.	92.43%	89.32%
Proportion of respondents that would rate their child's specialist seen most often an 8 or higher on a scale from 0-10 where 0 is the worst specialist possible and 10 is the best specialist possible.	91.55%	87.27%
Proportion of respondents that would rate their child's health plan an 8 or higher on a scale from 0-10 where 0 is the worst health plan possible and 10 is the best health plan possible.	88.33%	83.61%

CONCLUSION

CHIP AND SMHB: INVESTING TODAY IN MISSOURI'S FUTURE

It has been two decades since Missouri adopted its CHIP program. While the program has evolved over the years, one stalwart outcome has been greater access to health care for Missouri's children who otherwise would not have coverage—public or private. The rate of uninsured has decreased to 5.9% nationally in 2021 and progress has been made in improving health outcomes for children enrolled in the program. Satisfaction with the program also remains high among participants.

On July 1, 2019, Centers for Medicare & Medicaid Services (CMS) awarded 39 cooperative agreements in 25 states. Up to $48 million was made available from the Helping Ensure Access for Little Ones, Toddlers and Hopeful Youth by Keeping Insurance Delivery Stable Act (Healthy Kids Act). Missouri was one of those awardees to enroll and retain eligible children in Medicaid and CHIP.[30]

Improved health outcomes realized through CHIP and SMHB has been done with responsible stewardship of public resources and greater access to preventive care has helped children avoid emergency rooms and hospital stays. The data indicates that CHIP has not replaced private insurance coverage but rather fills a coverage gap for working families.

Longer-term health and financial benefits, as supported by the cited research, should also be considered in summarizing the impact of CHIP and SMHB in Missouri. Emerging evidence has suggested that greater access to health care coverage earlier in life supports long-term health, academic, and employment outcomes. These long-term outcomes of early access to care are especially promising in light of the relatively recent adoption of the SMHB program. Prenatal care provided through SMHB is already improving birth outcomes. With continued support, the potential for other lifetime outcome improvements is exponential.

[30] https://www.insurekidsnow.gov/

APPENDICES

APPENDIX 1: CHIP PREMIUMS

APPENDIX 2: MEDICAID AND CHIP ENROLLMENT BY COUNTY (EXCLUDES SMHB)

APPENDIX 3: SMHB ENROLLMENT BY COUNTY

APPENDIX 4: HOSPITALIZATION AND ER UTILIZATION RATES BY PAYER/PROGRAM (2001–2021)

APPENDIX 5: DMH-DSS WRAPAROUND SERVICE CODES AND TITLES

SEE SEPARATE DOCUMENT